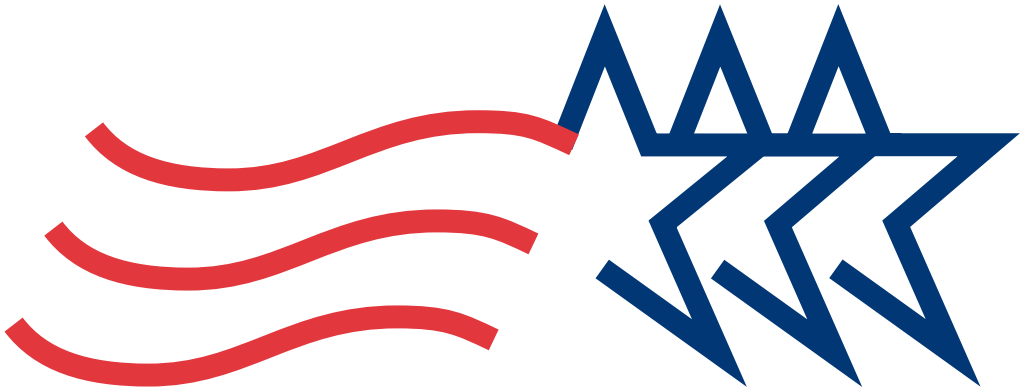
TRICARE PRIME

ENROLLMENT APPLICATION



TRICARE

Golden Gate · Hawaii · Southern California

Mail Completed Application To:
File 72893
Foundation Health Federal Services
P.O. Box 61000
San Francisco, CA 94161-2893

Note: *Your enrollment in TRICARE Prime will be effective once your application fee is paid (if needed), and your application has been processed. If your application is received before the 20th of the month, your membership will become effective the first day of the following month. Applications received after the 20th of the month will be effective the first day of the second month. For example, if your application is received on October 29th, your membership will become effective on December 1st. After your application is processed, you will receive a TRICARE Prime ID card that will list the official date of your membership in Prime. For additional enrollment questions, call (800) 242-6788.*

AGENCY DISCLOSURE STATEMENT

Public reporting burden for this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to the Department of Defense, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508. PLEASE DO NOT RETURN YOUR APPLICATION TO EITHER OF THESE ADDRESSES. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT

(1) Authority: 5 USC 552a, 10 USC 1079 and 1086, 58 FR 45318. (2) Purpose: To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR, Part 199.17). (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

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HOW TO USE THIS FORM:

1. Complete all of the sponsor's information in blocks 1-14.
2. Complete other relevant sections.
3. Sign and date the form at the bottom of the application.
4. If enrolling more than two family members, use section titled "Additional Family Member Information".
5. If you select the Quarterly Payment Plan, complete Quarterly Payment Application Section.
6. Call (800) 242-6788 if you need help completing this application.

Foundation Health℠ Federal Services, Inc.

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PRIME ENROLLMENT INSTRUCTIONS

Foundation Health℠ Federal Services, Inc.

Thank you for choosing the TRICARE Prime program. Please print in ink all information for the sponsor and each eligible family member being enrolled. If your family's personal information on this form does not match what DEERS has on file, or if information is missing, your application will be delayed. You can call DEERS at (800) 334-4162 (for Yuma, AZ residents: (800) 538-9552) to make sure that the information on this form matches their personal information records for your family. If you need help filling out this application, please call us at (800) 242-6788, and a representative will be happy to assist you. *If you are an eligible former spouse, you must complete a separate application for yourself and pay the appropriate fee.*

MAKE SURE ALL INFORMATION IS COMPLETE AND ACCURATE. PLEASE ALSO INDICATE IF YOU ARE TRANSFERRING FROM ANOTHER REGION.

1. Sponsor's Name - Last name, first name, middle initial.
2. Sponsor's Social Security Number.
3. Sponsor's Residence Address - Street, Apartment Number, City, State, Zip Code. **A RESIDENCE ADDRESS IS REQUIRED.**
4. Sponsor's Mailing Address - Street or Post Office Box (if appropriate), City, State, Zip Code
5. Sponsor's Sex.
6. Sponsor's Birthdate - Month, Day, Year.
7. Telephone Numbers - Sponsor (Home/Work), Spouse (Work).
8. Is the Sponsor active duty? Check the appropriate box. (Note: Active duty service members do not need to enroll in TRICARE Prime.)

9a. Sponsor's Military Rank – Corporal, Chief, Captain, etc.

9b. Sponsor's Military Pay Grade – E-1, E-2, E-3, etc.

9c. Unit of Assignment - Brigade, Wing, Ship, Station, etc.

9d. Flight Status - ❑ Yes ❑ No ❑ N/A

10. Sponsor's Branch of Service. Check the appropriate box.
11. Is the Sponsor deceased? Check the appropriate box and see the payment options at the Quarterly Payment Application Section of this enrollment form.
12. Is the Sponsor retired? Check the appropriate box and see the payment options at the Quarterly Payment Application Section of this enrollment form.
13. Is the Retired Sponsor enrolling? Check the appropriate box.
14. List the Primary Care Manager's Name, Address, City, State, Zip Code.
15. Family Member Information - List information for all eligible family members who are enrolling in the TRICARE Prime program. **You MUST select a Primary Care Manager for each family member being enrolled.** If more than two members are enrolling, please complete the same information on page 5 of the application. If you have more family members enrolling than space permits, please request an additional application. **A DEERS check is part of the enrollment process. Remember that all family members included on this application must be listed with DEERS in order to be eligible for TRICARE Prime. Contact DEERS at (800) 334-4162 (for Yuma, AZ residents: (800) 538-9552) to make sure your family members are listed in their records.**
16. If the Sponsor or eligible Family Members have other health coverage, including Medicare, **you must complete the attached Statement of Other Health Insurance.**
17. Indicate whether or not the Sponsor or eligible Family Members have chosen TRICARE Prime instead of other health insurance coverage provided through another source.
18. Indicate whether or not the Sponsor or eligible Family Members are participating in the Program for Persons With Disabilities (PFPWD).
19. Specify the last time the Sponsor or eligible Family Members used TRICARE Standard.
20. Indicate where you learned about the TRICARE Prime program.
21. Please review and initial each item to acknowledge your agreement.
22. If an enrollment fee is due, please indicate the method of payment. If you select quarterly payments, please fill out appropriate section. The application form will be processed and a TRICARE Prime identification card will be mailed to each enrolled member. The expiration date of enrollment will be indicated on each card. **The TRICARE Prime enrollment application must be signed by the sponsor, spouse, or other legal guardian of the family member being enrolled.**

KEEP THE YELLOW COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL APPLICATION FORM TO:
File 72893 • FHFS, Inc. • P.O. Box 61000 • San Francisco, CA 94161-2893
Or take the application to your nearest TRICARE Service Center or Beneficiary Service Office

STATEMENT OF OTHER HEALTH INSURANCE

Please complete the following information for each person enrolling in TRICARE Prime.

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Name of family members covered by TRICARE	Is this family member covered now or were they covered in the last 12 months by any other health insurance?	Does (or did) the other health insurance have prescription drug coverage?	Is (or was) the other health insurance supplemental coverage?	Name of the other health insurance company.	Date the other health insurance coverage went into effect.	Date of cancellation if policy is no longer in effect.
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			
	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No			

SPONSOR NAME:	SPONSOR SOCIAL SECURITY NUMBER:
APPLICANT/GUARDIAN* DAYTIME PHONE:	APPLICANT/GUARDIAN* EVENING PHONE:

APPLICANT/GUARDIAN* SIGNATURE:	RELATIONSHIP TO SPONSOR:	DATE:

***Parent or guardian if enrollee is under age 18.**

KEEP THE YELLOW COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL WITH YOUR TRICARE PRIME ENROLLMENT APPLICATION TO FHFS, INC.

TRICARE PRIME ENROLLMENT APPLICATION

SPONSOR INFORMATION

1) SPONSOR NAME LAST FIRST MI | 2) SPONSOR'S SOCIAL SECURITY NUMBER

3) RESIDENCE STREET ADDRESS | APT. NO. | CITY | STATE | ZIP

4) MAILING ADDRESS | CITY | STATE | ZIP

5) SEX ❑ M ❑ F | 6) BIRTHDATE MO. DAY YR. | 7) PHONE HOME: ( ) WORK: ( ) OTHER DAYTIME PHONE ( ) | 8) IS SPONSOR ACTIVE DUTY? ❑ YES ❑ NO

9a) SPONSOR'S RANK | 9b) SPONSOR'S PAY GRADE | 9c) UNIT OF ASSIGNMENT | 9d) FLYING STATUS ❑ YES ❑ NO ❑ N/A | 10) BRANCH OF SERVICE ❑ USAF ❑ USPHS ❑ NOAA ❑ US ARMY ❑ USN ❑ USMC ❑ USCG ❑ _____

11) IS SPONSOR DECEASED? ❑ YES ❑ NO DATE _____ | 12) IS SPONSOR RETIRED? ❑ YES ❑ NO | 13) IS RETIRED SPONSOR ENROLLING? ❑ YES ❑ NO

14) LIST PRIMARY CARE MANAGER NAME/CLINIC SITE COMPLETE ADDRESS

15) FAMILY MEMBER INFORMATION

IF ENROLLING MORE THAN ONE, CONTINUE WITH FAMILY MEMBER INFORMATION ON PAGE 5.

NAME LAST FIRST MI | RELATIONSHIP TO SPONSOR | SEX ❑ MALE ❑ FEMALE

ADDRESS CITY STATE ZIP | PHONE | BIRTHDATE MO. DAY YR.

SOCIAL SECURITY NUMBER | PRIMARY CARE MANAGER (PCM) **MUST BE COMPLETED** NAME / CLINIC SITE | IS THIS YOUR CURRENT PROVIDER? ❑ YES ❑ NO

PRIMARY CARE MANAGER'S ADDRESS CITY STATE ZIP

16) DO YOU OR YOUR FAMILY MEMBERS REQUESTING ENROLLMENT HAVE OTHER HEALTH COVERAGE, INCLUDING MEDICARE?
❑ YES ❑ NO IF YES, YOU MUST COMPLETE THE ATTACHED STATEMENT OF OTHER HEALTH INSURANCE.

17) DID YOU OR ANY FAMILY MEMBERS CHOOSE TRICARE PRIME INSTEAD OF COVERAGE THROUGH ANOTHER SOURCE? ❑ YES ❑ NO

18) ARE YOU, OR YOUR FAMILY MEMBERS REQUESTING ENROLLMENT, PARTICIPATING IN THE PROGRAM FOR PERSONS WITH DISABILITIES (PFPWD)? IF YES, PLEASE LIST PARTICIPANT(S) ❑ YES ❑ NO

19) WHEN WAS THE LAST TIME YOU OR ELIGIBLE FAMILY MEMBERS USED TRICARE STANDARD? ❑ PAST 12 MONTHS ❑ 2-5 YEARS ❑ OVER 5 YEARS ❑ NEVER, NEWLY ELIGIBLE FOR TRICARE ❑ NEVER, ALWAYS USE MILITARY FACILITIES

20) WHERE DID YOU HEAR ABOUT TRICARE PRIME?
❑ BASE NEWSPAPER ARTICLE ❑ AD / FLIER IN BASE NEWSPAPER ❑ MEDICAL PROVIDER ❑ TRICARE SERVICE CENTER ❑ LETTER ❑ NEWSLETTER ❑ FLYER WITH EOB/ CLAIM FORM

21) PLEASE INITIAL EACH ITEM BELOW TO ACKNOWLEDGE YOUR AGREEMENT.

_____ I have read the information provided to me in the TRICARE Prime, Extra and Standard booklet and hereby apply for enrollment. I understand that entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS).

_____ I understand that a Primary Care Manager (PCM); either a civilian network provider or clinic site, or a Military Treatment Facility (MTF) clinic site, must be assigned/selected as a PCM for all parties being enrolled.

_____ I understand that, except for emergencies, all TRICARE Prime services must be coordinated through the PCM. If care is obtained that has not been coordinated by the PCM and authorized by the Health Care Finder, I understand that I will be responsible for payment of charges in accordance with the provisions of the Point-of-Service (POS) option as described in the TRICARE Prime Member Handbook, and TRICARE regulations.

_____ I understand that enrollment in TRICARE Prime is for 12 consecutive months and that disenrollment is allowed after each 12-month enrollment period. I also understand that any enrolled family members who disenroll after the 12-month enrollment period, may re-enroll at anytime and may choose to disenroll prior to completing the 12-month enrollment period by requesting early disenrollment from the MTF Commander or the Lead Agent. I further understand that any enrolled family members will be disenrolled for non-payment of a quarterly enrollment fee by the due date or for any early disenrollment (unless they move). If I or any enrolled family members are disenrolled we may not re-enroll for a period of 12 months.

_____ I understand that the enrollment fee is non-refundable unless sponsor status changes from retired to active duty. However, if I or any enrolled family member transfers out of the TRICARE Golden Gate - Pacific/Hawaii - Southern California region, that person must not disenroll from their region until they have re-enrolled in the new region. If transferring out of the region, and relocating to a new non-TRICARE region, then the member should disenroll.

_____ I authorize Foundation Health Federal Services and/or its provider network subcontractor(s) to examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this application and/or attachment.

_____ I understand that Foundation Health Federal Services reserves the right to require beneficiary prepayment of prescription drug costs and submittal of a claim for determination of payment of benefits.

_____ If I am transferring my enrollment to a new region, I understand that my Prime benefits will transfer with me.

_____ If this is an enrollment transfer, I authorize the former contractor to disenroll the above members.

_____ I agree to waive the drive time if my Primary Care Manager is more than a 30-minute drive from my residence.

_____ I hereby certify that the information provided on the document is true and complete. I agree to abide by the provisions of membership in TRICARE Prime.

If you are required to pay an enrollment fee, please complete section 22. If you choose the "Quarterly Payment" option, please also complete the "Quarterly Payment Application Section" on the next page.

SIGNATURE | RELATIONSHIP TO SPONSOR | DATE

KEEP THE YELLOW COPY FOR YOUR RECORDS AND SEND THE ORIGINAL APPLICATION TO FHFS, Inc.

ADDITIONAL FAMILY MEMBER INFORMATION	SPONSOR'S SOCIAL SECURITY NUMBER: – –

NAME LAST FIRST MI	RELATIONSHIP TO SPONSOR	SEX ❑ MALE ❑ FEMALE	
ADDRESS CITY STATE ZIP	PHONE	BIRTHDATE MO. DAY YR.	
SOCIAL SECURITY NUMBER	PRIMARY CARE MANAGER (PCM) **MUST BE COMPLETED** NAME / CLINIC SITE	IS THIS YOUR CURRENT PROVIDER? ❑ YES ❑ NO	
PRIMARY CARE MANAGER'S ADDRESS	CITY	STATE	ZIP
NAME LAST FIRST MI	RELATIONSHIP TO SPONSOR	SEX ❑ MALE ❑ FEMALE	
ADDRESS CITY STATE ZIP	PHONE	BIRTHDATE MO. DAY YR.	
SOCIAL SECURITY NUMBER	PRIMARY CARE MANAGER (PCM) **MUST BE COMPLETED** NAME / CLINIC SITE	IS THIS YOUR CURRENT PROVIDER? ❑ YES ❑ NO	
PRIMARY CARE MANAGER'S ADDRESS	CITY	STATE	ZIP
NAME LAST FIRST MI	RELATIONSHIP TO SPONSOR	SEX ❑ MALE ❑ FEMALE	
ADDRESS CITY STATE ZIP	PHONE	BIRTHDATE MO. DAY YR.	
SOCIAL SECURITY NUMBER	PRIMARY CARE MANAGER (PCM) **MUST BE COMPLETED** NAME / CLINIC SITE	IS THIS YOUR CURRENT PROVIDER? ❑ YES ❑ NO	
PRIMARY CARE MANAGER'S ADDRESS	CITY	STATE	ZIP

ATTENTION ▶ Retiree / Retiree Family Member(s) and Survivors / Eligible Former Spouse

Quarterly Payment Application Section

1. You may pay your enrollment fee in quarterly installments.
2. You may elect to make a single quarterly payment at a time, or pay several quarterly payments in advance.
3. When you select a quarterly payment option, the amount enclosed must match the quarterly option selected, or your application might be delayed.
4. When paying enrollment fees on a quarterly basis, you will receive an invoice 30 days prior to your next quarterly payment due date. Even if you have not received a re-enrollment notice, it remains your responsibility to contact the TRICARE Service Center or Beneficiary Service Office before your enrollment period expires to avoid being disenrolled. DO NOT WAIT FOR NOTIFICATION TO RE-ENROLL AT THE APPROPRIATE TIME.
5. All family members can be disenrolled for non-payment of your quarterly enrollment fees. If this occurs, you and your family members may not re-enroll in TRICARE Prime for a period of 12 months. You may use TRICARE Standard or TRICARE Extra during the lockout period. This pertains to all family members eligible under the sponsor's Social Security Number (SSN).

Yes, I want to pay my TRICARE Prime enrollment fee on a quarterly basis. I have selected one of the following payment choices:

Choice 1:

❑ **Payment for the first quarter (first three months) of the TRICARE Prime annual enrollment fee. The next three payments will be due in three months, six months, and nine months.** ***Amount Due Now***

Retiree/Retiree Family Member Individual: .... $ 57.50
Retiree/Retiree Family Members Two or more: $115.00

Choice 2:

❑ **Payment for the first and second quarters (six months) of the TRICARE Prime annual enrollment fee. The next payment will be due in six months.** ***Amount Due Now***

Retiree/Retiree Family Member Individual: $115.00
Retiree/Retiree Family Members Two or more: $230.00

Choice 3:

❑ **Payment for the first, second and third quarters (first nine months) of the TRICARE Prime annual enrollment fee. The final payment will be due in nine months.** ***Amount Due Now***

Retiree/Retiree Family Member Individual: $172.50
Retiree/Retiree Family Members Two or more: $345.00

I hereby certify that I have read and understood the Quarterly Payment Application instructions and will abide by the quarterly payment option I have selected.

Signature ______________________________ Date ______________

22) IF AN ENROLLMENT FEE IS DUE, PLEASE INDICATE THE PAYMENT METHOD.

Payment was made in a previous region. ❑ Yes ❑ No

If yes, *and a quarterly payment is due within the next 60 days,* ***please submit payment with this application.***

If no, *please fill out the payment information below.*

Enrollment in TRICARE Prime is subject to validation of payment. You may not pay in cash.

❑ ANNUAL PAYMENT: ❑ $230 Individual ❑ $460 Two or More
❑ QUARTERLY PAYMENT: Complete the Quarterly Payment Application above

For Enrollment Portability who is responsible paying party:
❑ Sponsor ❑ Spouse ❑ Dependent (over the age of 18)

Make check or money order payable to: FHFS - TRICARE. No third party checks please.

❑ Check ❑ Cashier's Check ❑ Money Order ❑ Visa ❑ Mastercard

If paying by credit card, enter the card number and expiration date:

________ ________ ________ ________ Expiration Date: _____/_____

Print the credit card holder's name: ______________________

Card holder's signature: ______________________

The signature above authorizes Foundation Health Federal Services to charge the above account the appropriate TRICARE Prime enrollment fee.

FOR OFFICIAL USE ONLY

Amount Received: __________ Accepted By: ______________ TSC Location: ______________ Date: ______________